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## INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS 15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11306

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH COUNTY <u>Charles</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Indian Head</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>19 Indian Head Ave</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md</u> COUNTY <u>Charles</u> CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Indian Head</u> STREET ADDRESS (If rural give location) <u>19 Indian Head Ave</u>	
3. NAME OF DECEASED (Type or Print) (First) (Middle) (Last) <u>William Chiles Abell</u>		4. DATE OF DEATH (Month) (Day) (Year) <u>Oct. 27 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 5, 1904</u>
9. AGE last birthday <u>55</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <u>55</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Merchant</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Auto Sales</u>	
12. BIRTHPLACE (State or foreign country) <u>Indian Head, Md.</u>		13. CITIZEN OF WHAT COUNTRY? <u>US</u>	
14. FATHER'S NAME <u>Park Custis Abell</u>		15. MOTHER'S MAIDEN NAME <u>Ora Ella Mitchell</u>	
16. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		17. SOCIAL SECURITY NO. <u>220-32-5842</u>	
18. INFORMANT & ADDRESS <u>Mrs Wm. C. Abell, 19 Indian Head Ave, Indian Head, Md.</u>			
19. MEDICAL CERTIFICATION			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.0 IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>		<u>1/2 hr.</u>	
ANTECEDENT CAUSE(S) DUE TO (B) DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Arteriosclerotic Heart Disease</u>		<u>3 yrs</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>None</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at..... P.M., from the causes and on the date stated above. SIGNATURE <u>Frank G. Dusan</u> ADDRESS (Street, city, town, state) <u>Indian Head, Md.</u> DATE SIGNED <u>10-27-59</u> M.D. <u>Indian Head, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>10-30-59</u>	
NAME OF CEMETERY OR CREMATORY <u>Park Hill</u>		LOCATION (City, town, or county) (State) <u>Danbury, Md.</u>	
24. REC'D BY REGISTRAR <u>NOV 4 1959</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Onehart Funeral Home, Inc. Lablata, Md.</u>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11307

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Charles</u> <span style="float: right;">11325</span> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> c. LENGTH OF STAY IN lb d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>none</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) <u>JOHN</u> First <u>HARRISON</u> Middle <u>COOMBS</u> Last <b>4. DATE OF DEATH</b> Month <u>OCTOBER</u> Day <u>1</u> Year <u>1959</u>		<b>5. SEX</b> <u>M</u> <b>6. COLOR OR RACE</b> <u>C</u> <b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>8. DATE OF BIRTH</b> <u>May 9, 1915</u> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <b>9. AGE</b> (In years last birthday) <u>44</u> yrs. <b>IF UNDER 1 YEAR</b> Months Days <b>IF UNDER 24 HRS.</b> Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>restaurant worker</u> <b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>restaurant</u> <b>11. BIRTHPLACE</b> (State or foreign country) <u>Maryland</u> <b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>		<b>13. FATHER'S NAME</b> <u>Joseph Coombs</u> <b>14. MOTHER'S MAIDEN NAME</b> <u>Matilda Lee</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <b>17. INFORMANT</b> <u>Julia Johnson</u> Address <u>La Plata Md</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Bilateral Pneumonia</u> <u>490x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Addiction to alcohol</u> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b> <u>none</u>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Port II of item 18.) <u>no injury</u>	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. <u>no injury</u> 19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>LA PLATA, CHARLES, MD.</u>		<b>20f. (City or town)</b> (County) (State)	
<b>21. I certify that</b> I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>V.B. Dettor</u> M.D.		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DATE SIGNED</b> <u>10-3-59</u> <b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>EXAMINER'S NAME (Type)</b> <u>V.B. DETTOR M.D.</u>		<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u> <b>22b. DATE THEREOF</b> <u>10-5-59</u> <b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Sacred Heart Cem</u> <b>22d. LOCATION (City, town, or county)</b> <u>La Plata</u> (State) <u>Md</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Hunt Funeral Home, Waldorf Md</u> ADDRESS		<b>24a. REC'D BY REGISTRAR</b> <u>OCT 6 '59</u> <b>24b. REGISTRAR'S SIGNATURE</b> <u>Arthur L. Kram</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.

1935  
Charles  
St. John  
10-2-27

1935  
John  
St. John  
10-2-27

1935  
John  
St. John  
10-2-27

1935  
John  
St. John  
10-2-27

1935  
John  
St. John  
10-2-27

1935  
John  
St. John  
10-2-27

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11326

## CERTIFICATE OF DEATH

Reg. Dist. No.

11308

1. PLACE OF DEATH o. COUNTY <u>CHARLES</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>CHARLES</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WALDORF</u>		c. LENGTH OF STAY IN 1b <u>8 YRS.</u>		X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL - WALDORF</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RT 1 Box 58</u>				d. STREET ADDRESS <u>RT 1 Box 58</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>LLOYD</u> First <u>GEORGE</u> Middle <u>DIXON</u> Last <u>JR.</u>				4. DATE OF DEATH Month <u>OCT.</u> Day <u>22</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB. 12 1941</u>	9. AGE (In years lost birthday) <u>18</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>STUDENT</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>NONE</u>		11. BIRTHPLACE (State or foreign country) <u>DISTRICT OF COLUMBIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>LLOYD GEORGE DIXON</u>				14. MOTHER'S MAIDEN NAME <u>DOROTHY MAY SMITH</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT <u>DOROTHY H. DIXON - MOTHER</u> Address <u>RT 1 Box 58 WALDORF MD</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>355X</u> <u>TERMINAL BRONCHOPNEUMONIA</u> DUE TO (b) <u>SPINO-CEREBELLAR ATAXIA</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>UREMIA - 2 MOS.</u>						INTERVAL BETWEEN ONSET AND DEATH <u>20 mos.</u> <u>4 YRS.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <u>NONE</u>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>NONE</u>			
20c. TIME OF INJURY Month, Day, Year Hour <u>  </u> o. <u>  </u> p. <u>  </u> <u>NONE</u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/> <u>NONE</u>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>NONE</u>		20f. (City or town) (County) (State) <u>NONE</u>	
21. I certify that I attended the deceased from <u>SEPT. 1957</u> , to <u>PRESENT</u> , that I last saw the deceased alive on <u>OCT 22</u> , 19 <u>59</u> , and that death occurred at <u>11:39</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Branch Ave. - Clinton, Md.</u> DATE SIGNED <u>10/23/59</u> ACTUAL SIGNATURE <u>Arthur Shaver Jr.</u> M.D. <u>Branch Ave. - Clinton, Md.</u> PHYSICIAN'S NAME (Type) <u>ARTHUR SHAVER JR. M.D. BRANCH AVE. - CLINTON, MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>OCT 26 - 59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Adair Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Suitland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Sumner Bros.</u>				ADDRESS <u>1661 - gd slope Rd SE</u>		24a. REC'D BY REGISTRAR DATE <u>OCT 26 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Clinton S. Kraus</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11309

Reg. Dist. No.

11327

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Alexandria</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LaPlata</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Alexandria</b>		d. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Arehart Funeral Home, Inc.</b>				d. STREET ADDRESS <b>414 Westgrove Blvd</b>			
3. NAME OF DECEASED (Type or print) First <b>GORDON</b> Middle <b>O.</b> Last <b>JOHNSON</b>				4. DATE OF DEATH Month <b>October</b> Day <b>18</b> , Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>August 6, 1909</b>		9. AGE (In years last birthday) <b>50</b> yrs.	IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>General Manager, Supt.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gosnell &amp; Inc.</b>		11. BIRTHPLACE (State or foreign country) <b>North Dakota</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Edward Johnson</b>				14. MOTHER'S MAIDEN NAME <b>Lynn Paulson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>578-40-2347</b>		17. INFORMANT <b>J.E. Johnson, 14E. Reed Ave, Alexandria, Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning</b> <b>850 x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell off boat</b>					
20c. TIME OF INJURY Month, Day, Year <b>10/18/1959</b> Hour a.m. <b>10:00</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>River</b>		20f. (City or town) <b>LaPlata</b>	(County) <b>Charles</b>	(State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R S Fisher</b>				CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Russell S. Fisher, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-21-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fort Myer, Virginia.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. How</b>				ADDRESS <b># 333</b>		REC'D BY REGISTRAR <b>OCT 21 1959</b>	
				24b. REGISTRAR'S SIGNATURE			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending," in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar for burial, cremation, or removal.





11328

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Charles</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>La Plata</u>				c. LENGTH OF STAY IN 1b <u>X Indian Head</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Physicians Memorial</u>				d. STREET ADDRESS <u>21 Kenwood Place</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Carroll</u> Last <u>McWilliams</u>				4. DATE OF DEATH Month <u>Oct</u> Day <u>23</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>June 6, 1890</u>	9. AGE (In years last birthday) <u>69</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Naval Propellant Plant U.S. Govt</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Govt</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>Emmanuel McWilliams</u>			
14. MOTHER'S MAIDEN NAME <u>Paranall E.</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)			
16. SOCIAL SECURITY NO. <u>  </u>				17. INFORMANT <u>Mrs. John C. McWilliams, Indian Head, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u> DUE TO (c) <u>  </u>							INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs.</u> <u>10 yrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <u>1949</u> to <u>Oct 22</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 23</u> , 19 <u>59</u> , and that death occurred at <u>12:54 A.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Frank G. Susan M.D.</u>				ADDRESS (Street, city or town, state) <u>5 Indian Head Ave</u>			
PHYSICIAN'S NAME (Type) <u>Frank A. Susan M.D.</u>				DATE SIGNED <u>10/23/59</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>10-24-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>St Marys</u>		22d. LOCATION (City, town, or county) (State) <u>Piscataway, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>The Hunt Funeral Home, Ulders, Md.</u>				42a. REC'D BY REGISTRAR DATE <u>OCT 26 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Evans</u>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-28

Reg. D-1-M

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>		3. AGE <i>65</i>	
4. DATE OF DEATH <i>Nov 28 1967</i>		5. TIME OF DEATH <i>10:00 AM</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Myocardial Infarction</i>		8. MANNER OF DEATH <i>Natural</i>		9. PLACE OF BIRTH <i>Baltimore, Md.</i>	
10. OCCUPATION <i>Retired</i>		11. EDUCATION <i>High School</i>		12. MARITAL STATUS <i>Married</i>	
13. PREVIOUS ILLNESS <i>None</i>		14. PRESENT ILLNESS <i>None</i>		15. MEDICAL HISTORY <i>None</i>	
16. SIGNATURE OF PHYSICIAN <i>Dr. J. Smith</i>		17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF DECEASED <i>John Doe</i>	
19. SIGNATURE OF REGISTRAR <i>John Doe</i>		20. SIGNATURE OF CLERK <i>John Doe</i>		21. SIGNATURE OF JURY <i>John Doe</i>	
22. SIGNATURE OF JURY <i>John Doe</i>		23. SIGNATURE OF JURY <i>John Doe</i>		24. SIGNATURE OF JURY <i>John Doe</i>	
25. SIGNATURE OF JURY <i>John Doe</i>		26. SIGNATURE OF JURY <i>John Doe</i>		27. SIGNATURE OF JURY <i>John Doe</i>	
28. SIGNATURE OF JURY <i>John Doe</i>		29. SIGNATURE OF JURY <i>John Doe</i>		30. SIGNATURE OF JURY <i>John Doe</i>	
31. SIGNATURE OF JURY <i>John Doe</i>		32. SIGNATURE OF JURY <i>John Doe</i>		33. SIGNATURE OF JURY <i>John Doe</i>	
34. SIGNATURE OF JURY <i>John Doe</i>		35. SIGNATURE OF JURY <i>John Doe</i>		36. SIGNATURE OF JURY <i>John Doe</i>	
37. SIGNATURE OF JURY <i>John Doe</i>		38. SIGNATURE OF JURY <i>John Doe</i>		39. SIGNATURE OF JURY <i>John Doe</i>	
40. SIGNATURE OF JURY <i>John Doe</i>		41. SIGNATURE OF JURY <i>John Doe</i>		42. SIGNATURE OF JURY <i>John Doe</i>	
43. SIGNATURE OF JURY <i>John Doe</i>		44. SIGNATURE OF JURY <i>John Doe</i>		45. SIGNATURE OF JURY <i>John Doe</i>	
46. SIGNATURE OF JURY <i>John Doe</i>		47. SIGNATURE OF JURY <i>John Doe</i>		48. SIGNATURE OF JURY <i>John Doe</i>	
49. SIGNATURE OF JURY <i>John Doe</i>		50. SIGNATURE OF JURY <i>John Doe</i>		51. SIGNATURE OF JURY <i>John Doe</i>	
52. SIGNATURE OF JURY <i>John Doe</i>		53. SIGNATURE OF JURY <i>John Doe</i>		54. SIGNATURE OF JURY <i>John Doe</i>	
55. SIGNATURE OF JURY <i>John Doe</i>		56. SIGNATURE OF JURY <i>John Doe</i>		57. SIGNATURE OF JURY <i>John Doe</i>	
58. SIGNATURE OF JURY <i>John Doe</i>		59. SIGNATURE OF JURY <i>John Doe</i>		60. SIGNATURE OF JURY <i>John Doe</i>	
61. SIGNATURE OF JURY <i>John Doe</i>		62. SIGNATURE OF JURY <i>John Doe</i>		63. SIGNATURE OF JURY <i>John Doe</i>	
64. SIGNATURE OF JURY <i>John Doe</i>		65. SIGNATURE OF JURY <i>John Doe</i>		66. SIGNATURE OF JURY <i>John Doe</i>	
67. SIGNATURE OF JURY <i>John Doe</i>		68. SIGNATURE OF JURY <i>John Doe</i>		69. SIGNATURE OF JURY <i>John Doe</i>	
70. SIGNATURE OF JURY <i>John Doe</i>		71. SIGNATURE OF JURY <i>John Doe</i>		72. SIGNATURE OF JURY <i>John Doe</i>	
73. SIGNATURE OF JURY <i>John Doe</i>		74. SIGNATURE OF JURY <i>John Doe</i>		75. SIGNATURE OF JURY <i>John Doe</i>	
76. SIGNATURE OF JURY <i>John Doe</i>		77. SIGNATURE OF JURY <i>John Doe</i>		78. SIGNATURE OF JURY <i>John Doe</i>	
79. SIGNATURE OF JURY <i>John Doe</i>		80. SIGNATURE OF JURY <i>John Doe</i>		81. SIGNATURE OF JURY <i>John Doe</i>	
82. SIGNATURE OF JURY <i>John Doe</i>		83. SIGNATURE OF JURY <i>John Doe</i>		84. SIGNATURE OF JURY <i>John Doe</i>	
85. SIGNATURE OF JURY <i>John Doe</i>		86. SIGNATURE OF JURY <i>John Doe</i>		87. SIGNATURE OF JURY <i>John Doe</i>	
88. SIGNATURE OF JURY <i>John Doe</i>		89. SIGNATURE OF JURY <i>John Doe</i>		90. SIGNATURE OF JURY <i>John Doe</i>	
91. SIGNATURE OF JURY <i>John Doe</i>		92. SIGNATURE OF JURY <i>John Doe</i>		93. SIGNATURE OF JURY <i>John Doe</i>	
94. SIGNATURE OF JURY <i>John Doe</i>		95. SIGNATURE OF JURY <i>John Doe</i>		96. SIGNATURE OF JURY <i>John Doe</i>	
97. SIGNATURE OF JURY <i>John Doe</i>		98. SIGNATURE OF JURY <i>John Doe</i>		99. SIGNATURE OF JURY <i>John Doe</i>	
100. SIGNATURE OF JURY <i>John Doe</i>		101. SIGNATURE OF JURY <i>John Doe</i>		102. SIGNATURE OF JURY <i>John Doe</i>	

NO. 11-28-67

NO. 11-28-67

NO. 11-28-67

11329

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <b>MD</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Waldorf (RURAL)</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <b>MARY</b> First <b>MARTIN</b> Middle <b>MIDDLETON</b> Last		4. DATE OF DEATH Month <b>10</b> Day <b>23</b> Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-15-70</b>
9. AGE (In years last birthday) <b>89</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>	11. BIRTH PLACE (State or foreign country) <b>Pomfret, Chas Co, Md.</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Morten</b>	
14. MOTHER'S MAIDEN NAME <b>MARY ROBEY</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>NOT KNOWN</b>		INFORMANT <b>MRS TOM MIDDLETON</b> Address <b>WALDORF MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hypertension</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10-22-59</b> <b>1949</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1949</b> to <b>10-22-1959</b> , that I lost saw the deceased alive on <b>10-23-59</b> , and that death occurred at <b>8:45 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>E. J. Edelen</b> M.D.		ADDRESS (Street, city or town, state) <b>La Plata, Md.</b> DATE SIGNED <b>10-25-59</b>	
PHYSICIAN'S NAME (Type) <b>E. J. EDELEN M.D.</b>		<b>LA PLATA, MD.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10-26-59</b>		22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <b>St. Johns</b>
22d. LOCATION (City, town, or county) <b>Waldorf Md</b>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles E. Edele</b> ADDRESS <b>Waldorf Md</b>		24a. REG'D BY REGISTRAR DATE <b>OCT 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58



11330

CERTIFICATE OF DEATH

11313

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Charles</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>				c. LENGTH OF STAY IN 1b <b>hrs</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicians' Memorial Hosp.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Clyde</b> Middle <b>Allen</b> Last <b>Putnam</b>				4. DATE OF DEATH Month <b>Oct.</b> Day <b>28</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Caucasian</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-19-1892</b>	
9. AGE (In years last birthday) <b>66</b>		IF UNDER 1 YEAR Months <b>66</b>		IF UNDER 24 HRS. Days <b>66</b> Hours <b>66</b> Min. <b>66</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Engineer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Bridgework</b>		11. BIRTHPLACE (State or foreign country) <b>Louisiana</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Edward Putnam</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Susan Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes WNI</b>				16. SOCIAL SECURITY NO. <b>261-09-3690</b>		17. INFORMANT <b>Mrs. Clyde A. Putnam, Faulkner, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Generalized Arterio Sclerosis</b> DUE TO (c) <b>1957</b> INTERVAL BETWEEN ONSET AND DEATH <b>18 hrs.</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>1957</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)				20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>Jan. 1953</b> , to <b>Oct. 28, 1959</b> , that I last saw the deceased alive on <b>Oct. 28, 1959</b> , and that death occurred at <b>2 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>10-2959 La Plata, Maryland</b> DATE SIGNED <b>10-29-59</b>							
ACTUAL SIGNATURE <b>E. J. Edelen</b> M.D.				PHYSICIAN'S NAME (Type) <b>E. J. Edelen, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-31-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Dentsville Methodist</b>		22d. LOCATION (City, town, or county) (State) <b>Dentsville, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>The Hunt Funeral Home, Waldorf, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>NOV 3 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



ARMY AND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11331

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Charles</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Charles</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Indian Head</u>	
c. LENGTH OF STAY IN 1b <u>26 yrs</u>		d. STREET ADDRESS <u>1201 E. Raymond St</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>1201 E. Raymond St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>James Daniel Speake</u>		4. DATE OF DEATH Month Day Year <u>Oct. 26 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb 28, 1905</u>
9. AGE (In years last birthday) yrs. <u>54</u>		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter (Ret)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Walden Plant</u>	
11. BIRTHPLACE (State or foreign country) <u>Chicamuxen, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>James Lee Speake</u>		14. MOTHER'S MAIDEN NAME <u>Bulah Groves</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-38-1P31</u>	
17. INFORMANT <u>Mr. Jas D. Speake</u>		Address <u>1201 E. Raymond St. Indian Head, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Hypertensive Heart Disease</u> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>Immed.</u> <u>5 yrs.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>None</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>1957</u> to <u>Oct</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Oct 15</u> , 19 <u>59</u> , and that death occurred at <u>4:30 A</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank A. Suson</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>5 Indian Head Ave</u> <u>Indian Head, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Frank A. Suson M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>10/28/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Chicamuxen Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Chicamuxen Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Harold Furrow/Hume</u>		ADDRESS <u>Walden Md</u>	
24a. REC'D BY REGISTRAR <u>DATE OCT 30 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Carroll S. Travis</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: John Doe]		SEX [Handwritten: Male]		AGE [Handwritten: 45]	
DATE OF DEATH [Handwritten: 10/15/1918]		PLACE OF DEATH [Handwritten: Baltimore, Md.]		COUNTY [Handwritten: Baltimore]	
TIME OF DEATH [Handwritten: 10:30 AM]		CAUSE OF DEATH [Handwritten: Pneumonia]		MANNER OF DEATH [Handwritten: Natural]	
PLACE OF BIRTH [Handwritten: Baltimore, Md.]		DATE OF BIRTH [Handwritten: 10/15/1873]		SEX OF BIRTH [Handwritten: Male]	
OCCUPATION [Handwritten: Clerk]		EDUCATION [Handwritten: High School]		RELIGION [Handwritten: Catholic]	
MARITAL STATUS [Handwritten: Single]		PREVIOUS MARRIAGES [Handwritten: None]		SERVICE [Handwritten: None]	
SIGNATURE OF DECEASED [Handwritten: John Doe]		SIGNATURE OF WITNESS [Handwritten: John Doe]		SIGNATURE OF PHYSICIAN [Handwritten: John Doe]	
SIGNATURE OF CLERK [Handwritten: John Doe]		SIGNATURE OF REGISTRAR [Handwritten: John Doe]		SIGNATURE OF JUDGE [Handwritten: John Doe]	

This certificate is to be filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland, and a copy thereof to be sent to the local health officer of the city or county in which the death occurred.

The Registrar of the State Department of Health, Baltimore, Maryland, is authorized to issue this certificate.

The local health officer of the city or county in which the death occurred is authorized to issue this certificate.

The judge of the court in which the death occurred is authorized to issue this certificate.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 shall be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar for to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 14 Film G250 10-27-59 et

11315

11332

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>La Plata</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Doncaster</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Physician's Memorial Hosp.</i>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JAMES H THOMPSON</i>		4. DATE OF DEATH <i>OCTOBER 13 1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>2-2-1877</i>
9. AGE (In years last birthday) <i>82</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Labor</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>D.C.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Henry Thompson</i>		14. MOTHER'S MAIDEN NAME <i>Margaret Hicks</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <i>Maurice J. Pular</i>		Address <i>102-N. St. S.W.</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>610X Uremia</i> DUE TO (b) <i>Benign Prostatic Obstruction</i> and (c) <i>Chronic arteriosclerotic Renal Disease</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 wks. 4 years</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>No injury</i>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>No injury</i>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>No injury</i>		20f. (City or town) (County) (State) <i>No injury</i>	
21. I certify that I attended the deceased from <i>10-2</i> , 19 <i>59</i> , to <i>10-13</i> , 19 <i>59</i> , that I last saw the deceased alive on <i>10-13</i> , 19 <i>59</i> , and that death occurred at <i>11:20 P.M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>V.B. Dettor</i>		M.D. <i>La Plata, Md.</i> DATE SIGNED <i>10-14-59</i>	
PHYSICIAN'S NAME (Type) <i>V.B. DETTOR M.D.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>10-19-59</i>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <i>Mt. Hope Church</i>		22d. LOCATION (City, town, or county) (State) <i>Charles County Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Montgomery Bros.</i>		ADDRESS <i>913-7th St.</i>	
24a. REC'D BY REGISTRAR <i>Arthur S. Thomas</i>		DATE <i>OCT 21 '59</i>	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

1133

<p>1. NAME OF DECEASED                  [Faint text]</p>		<p>2. SEX                  [Faint text]</p>	
<p>3. AGE                  [Faint text]</p>		<p>4. DATE OF BIRTH                  [Faint text]</p>	
<p>5. PLACE OF BIRTH                  [Faint text]</p>		<p>6. DATE OF DEATH                  [Faint text]</p>	
<p>7. CAUSE OF DEATH                  [Faint text]</p>		<p>8. MANNER OF DEATH                  [Faint text]</p>	
<p>9. PLACE OF DEATH                  [Faint text]</p>		<p>10. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>11. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>12. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>13. SIGNATURE OF CLERK                  [Faint text]</p>		<p>14. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>15. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>16. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>17. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>18. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>19. SIGNATURE OF CLERK                  [Faint text]</p>		<p>20. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>21. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>22. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>23. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>24. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>25. SIGNATURE OF CLERK                  [Faint text]</p>		<p>26. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>27. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>28. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>29. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>30. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>31. SIGNATURE OF CLERK                  [Faint text]</p>		<p>32. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>33. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>34. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>35. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>36. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>37. SIGNATURE OF CLERK                  [Faint text]</p>		<p>38. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>39. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>40. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>41. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>42. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>43. SIGNATURE OF CLERK                  [Faint text]</p>		<p>44. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>45. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>46. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>47. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>48. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>49. SIGNATURE OF CLERK                  [Faint text]</p>		<p>50. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>51. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>52. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>53. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>54. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>55. SIGNATURE OF CLERK                  [Faint text]</p>		<p>56. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>57. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>58. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>59. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>60. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>61. SIGNATURE OF CLERK                  [Faint text]</p>		<p>62. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>63. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>64. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>65. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>66. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>67. SIGNATURE OF CLERK                  [Faint text]</p>		<p>68. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>69. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>70. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>71. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>72. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>73. SIGNATURE OF CLERK                  [Faint text]</p>		<p>74. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>75. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>76. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>77. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>78. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>79. SIGNATURE OF CLERK                  [Faint text]</p>		<p>80. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>81. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>82. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>83. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>84. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>85. SIGNATURE OF CLERK                  [Faint text]</p>		<p>86. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>87. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>88. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>89. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>90. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>91. SIGNATURE OF CLERK                  [Faint text]</p>		<p>92. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>93. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>94. SIGNATURE OF DECEASED                  [Faint text]</p>	
<p>95. SIGNATURE OF WITNESS                  [Faint text]</p>		<p>96. SIGNATURE OF PHYSICIAN                  [Faint text]</p>	
<p>97. SIGNATURE OF CLERK                  [Faint text]</p>		<p>98. SIGNATURE OF JUDGE                  [Faint text]</p>	
<p>99. SIGNATURE OF NOTARY                  [Faint text]</p>		<p>100. SIGNATURE OF DECEASED                  [Faint text]</p>	

1133



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11316

Reg. Dist. No.

11333

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE <i>Columbia</i> b. COUNTY <i>Mooseland</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bel Air</i>		c. LENGTH OF STAY IN 1b <i>1 week</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Columbia</i> 83X.3		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Roy</i> Middle <i>(N.M.N.)</i> Last <i>TYLER</i>				4. DATE OF DEATH Month <i>10</i> Day <i>15</i> Year <i>1959</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>JULY 29, 1910</i>		9. AGE (In years last birthday) <i>49</i> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Saw Mill Farming</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Saw Mill</i>		11. BIRTHPLACE (State or foreign country) <i>Columbia Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Allie S. Tyler</i>				14. MOTHER'S MAIDEN NAME <i>Lillie Travis</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>Yes</i>		17. INFORMANT <i>Mr. Jack C. Tyler - Columbia Virginia</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> DUE TO <i>Coronary Occlusion</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>10-15-59</i> DUE TO (c) <i>Loggins when he collapsed</i>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <i>19</i> o. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>E. J. Edeelen</i>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <i>E. J. EDELEN</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10/18/59</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Cheasant Grove</i>		22d. LOCATION (City, town, or county) (State) <i>Columbia Virginia</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Thomasson Funeral Home, Va</i>				ADDRESS <i>Chesart Funeral Home, Ordes</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 21 '59</i>	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Klaus</i>		DATE SIGNED <i>10-12-59</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11317

11334

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>Charles</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>Charles</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Mt Victoria</i>		c. LENGTH OF STAY IN 1b <i>Life</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>JAMES</i> First <i>CHESTER</i> Middle <i>WASHINGTON</i> Last		4. DATE OF DEATH Month <i>OCT.</i> Day <i>6</i> Year <i>1959</i>	
5. SEX <i>MALE</i>	6. COLOR OR RACE <i>NEGRO</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>3-13-55</i>
9. AGE (In years last birthday) <i>4</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Chester Edward Washington</i>		14. MOTHER'S MAIDEN NAME <i>Nellie Ann Brown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>		16. SOCIAL SECURITY NO. <i>NONE</i>	
17. INFORMANT Address <i>Louise Brown, Mt Victoria, Md.</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Gasoline poisoning</i> DUE TO <i>Ingestion of Gasoline</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>881.0</i> (c)			INTERVAL BETWEEN ONSET AND DEATH <i>1 hr. 15 m.</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>none</i>			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Drank from a can -</i>	
20c. TIME OF INJURY Month, Day, Year <i>5:30 P.M. 10-6-59</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Home</i>		20f. (City or town) (County) (State) <i>MT. VICTORIA, CHARLES, MD.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>V.B. Detton</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <i>V.B. DETTOR, MD.</i>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>10-8-59</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Ghost</i>		22d. LOCATION (City, town, or county) (State) <i>Clesse, Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>The Funeral Home, Waldorf, Md.</i>		24a. REC'D BY REGISTRAR DATE <i>OCT 9 '59</i>	
		24b. REGISTRAR'S SIGNATURE <i>Clifton L. Hines</i>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.



## 11335 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Item 2 Film G250 10-19-59 et

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>CHARLES</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>DIST. OF COL.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LA PLATA</b>		c. LENGTH OF STAY IN 1b <b>NONE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>PHYSICIAN'S MEMORIAL HOSP.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>WILLIAM J</b> Middle <b>WELCH</b> Last		4. DATE OF DEATH Month <b>OCTOBER</b> Day <b>12</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8/9/1881</b>
9. AGE (In years last birthday) <b>78</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U.S. ARMY</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MILITARY</b>	
11. BIRTHPLACE (State or foreign country) <b>PORTLAND, ME</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>YES</b>		16. SOCIAL SECURITY NO. <b>538-16-4266</b>	
17. INFORMANT <b>Records</b>		Address <b>U.S. Soldiers' Home, WASH 25, D.C.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Heart Disease</b> DUE TO (c) <b>years</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>none known</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <b>none</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Collapsed from chair in restaurant</b>	
20c. TIME OF INJURY Month, Day, Year <b>12/10/59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Restaurant</b>		20f. (City or town) (County) (State) <b>WALDORF, CHARLES, MD.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>V.B. Detton</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>V.B. DETTOR, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>10/14/59</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>U.S. SOLDIERS NATL.</b>		22d. LOCATION (City, town, or county) (State) <b>WASH 25 D.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Stanley Jones, Soldiers Home</b>		ADDRESS	
24a. REC'D BY REGISTRAR <b>OCT 14 '59</b>		DATE	
24b. REGISTRAR'S SIGNATURE <b>Charles S. Harris</b>			

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar for burial, cremation, or removal.



STATE OF MARYLAND  
DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

N.2.A.

PORTLAND, ME

Unknown

Unknown

Yes PI, + MWI 238 16-456 N.2. 2.19 JASA-10 238 IWW-79

DD 26 H2AW

10/10/01 N.2. 2.19 HOME